KIDCARE PEDIATRICS
PRENATAL VISIT

BABY'S MOTHER

Name: _____Age: _____
Address: _____ Home Phone #: _____
Marital Status: _____Married _____Single Occupation: _____
Number of previous pregnancies: _____Number of living Children: ____
Problems with Previous Pregnancies: _____
_____

Number of children delivered prematurely (prior to 38 weeks gestation)? _____

Have any of your previous children had any of the following:
_____Newborn Jaundice _____SIDS (Sudden Infant Death Syndrome)
_____Congenital Heart Disease _____Serious infection in the newborn period (first 30 days)

During this pregnancy, have you:
_____Smoked? If yes, how much? _____
_____Drank alcoholic beverages? If yes, how much? _____
_____Taken Prescription or Nonprescription Drugs? If yes, which drugs? ____
_____

During this pregnancy, or at any time in the past, have you been diagnosed with:

_____Thyroid Disease	_____Diabetes	_____Epilepsy
_____Fifth's Disease	_____Sickle Cell Disease	_____Herpes
_____High Blood Pressure	_____Group B Strep.	_____Lupus
_____Bleeding Disorder	_____Toxoplasmosis	_____Asthma
_____Hepatitis	_____CMV (Cytomegalovirus) Infection	
_____Rubella	Other: _____	

BABY'S FATHER:

Name:_____Age:_____
Occupation: _____
Health Problems: _____

BABY'S BROTHERS AND/OR SISTERS

Name: Age: Health Problems:
_____
_____
_____
_____Are any of the siblings current patients at Kid Care Pediatrics? ____ Y ____ N

THIS PREGNANCY: When is your due date? _____
Do you anticipate a _____vaginal or _____ C-section delivery?
Who is your obstetrician? _____Where will you deliver? _____
Do you plan to: _____Breast Feed _____Bottle Feed _____Breast & Bottle Feed
Formula Preference: _____
Baby's sex: ___Boy ___Girl Baby's Name _____
If you have a boy, will you request a circumcision? _____Yes _____No
Do you have a car seat for the baby? _____Yes _____No
Did you attend childbirth classes? _____Yes _____No
Will you be returning to a job after delivery? _____Yes _____No

FAMILY MEDICAL HISTORY: Please answer the following regarding your family medical background. Circle Yes or No, and add comments where appropriate.

Yes	No	Any tobacco smokers in your household?	Yes	No	Asthma?
			Yes	No	Emphysema?
Yes	No	Family with high cholesterol?	Yes	No	Liver Diseases?
Yes	No	Heart attacks or Strokes Before 50 years?	Yes	No	Hepatitis B?
			Yes	No	Cirrhosis?
Yes	No	Diabetes in kids under 18 years of age?	Yes	No	Other?
			Yes	No	Pancreas Disease?
Yes	No	Diabetes in adults?	Yes	No	Ulcer Disease?
Yes	No	High Blood Pressure?	Yes	No	Hearing Deficits?
Yes	No	Kidney Disease?	Yes	No	Learning Disorder?
Yes	No	Kidney Stones?	Yes	No	Autism
Yes	No	Food Allergies?	Yes	No	ADD/ADHD
Yes	No	Anesthetic Reaction?	Yes	No	Immune Deficiency
Yes	No	Seizures due to fever?			Diseases?
Yes	No	Intellectual Disability?	Yes	No	Arthritis?
Yes	No	Chromosomal Abnormalities	Yes	No	Lupus?
Yes	No	Endocrine Diseases?	Yes	No	Bleeding Disorders?
Yes	No	Thyroid Gland?	Yes	No	Chronic Anemia?
Yes	No	Growth Hormone?	Yes	No	Sickle Cell Anemia?
Yes	No	Adrenal Gland?	Yes	No	Thalassemia?
Yes	No	Pituitary Gland?	Yes	No	Eczema or Psoriasis?
Yes	No	Cystic Fibrosis?	Yes	No	Cancer?
Yes	No	Eye Disease?			Type:_____

_____
_____
_____
_____
_____